REQUIRED INFO HIGHLIGHTED

Employer

NAME OF EMPLOYER (trading as or doing business as, if applicable)

2. Federal Tax ID No.

3. Employer's Case Number

4. MAILING ADDRESS

5LOCATION (IF DIFFERENT)

6. Parent Corporation/Policy Named Insured

7. NATURE OF BUSINESS

8. Name of Insurer and Address

9. Policy Number

10. Effective Date

Time and Place of Accident

11. City or County where accident occurred

12. DATE of Injury

13. HOUR of Injury

14. Date of Incapacity

15. Hour of Incapacity

16.Was Employee paid in full for day of injury?

Yes No Unknown

17. Was Employee paid in full for day incapacity began?

Yes No Unknown

18. Date Injury or Illness Reported

19.PERSON to whom Reported

20. Name of other witness

21. If fatal - Date of Death

Employee

22. NAME OF EMPLOYEE LAST,FIRST,MIDDLE

23. PHONE number

24. GENDER

Male

Female

25.ADDRESS

26. DATE OF BIRTH

27. Marital Status

Single

Divorced

Married

Widowed

28. SOCIAL SECURITY NUMBER

29. Occupation at time of injury or illness

30. DEPARTMENT NAME AND NUMBER

31. Number of Dependents

32. How Long in Current Position?

33. How Long with Current Employer?

34. Was employee paid on a piece work or hourly basis?

Piece work Hourly

35. Hours worked per day

36. Days worked per week

37. Value of perquisites per week

38. Wages per Hour

39. Earnings per week (incl. overtime)

Food /Meals

Lodging

Tips

Other

Nature and Cause of Accident

40. Machine, tool, or object causing injury or illness

41. Specify part of machine, etc.

42. DESCRIBE FULLY HOW INJURY OCCURRED:

43. DESCRIBE the nature of injury or illness, including parts of body effected:

44. Physician (name and address)

45. Hospital (name and address)

46. Probable length of Disability

47. HAS EMPLOYEE RETURNED TO WORK? ☐ Yes ☐ No ☐ Unknown

If yes

48. At what wage?

49. On what date?

50. EMPLOYER: prepared by (Name, Title)

51. DATE

52. PHONE NUMBER

Additional Information Related to the Claim

Notes

I understand that if medical treatment is necessary, I MUST select from the approved panel of physicians listed below. Please mark

Selected Physician

Powledge, Occupational Medicine, 5049 Valley View Blvd, Suite B, 362-9620 _____

Dr. Hartley, Carilion Occ. Med, Community Hospital, Elm Avenue, 985-8521 _____

Dr. Castern, Occ. Med, Lewis Gale Clinic, Braeburn Drive, Salem, 772-3470 _____